SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

Filing at a Glance

Company: Physicians Mutual Insurance Company

Product Name: B360 & A142-1	SERFF Tr Num: PHYS-125919161	State: ArkansasLH
TOI: H14I Individual Health - Hospital Indemnity	SERFF Status: Closed	State Tr Num: 40979
Sub-TOI: H14I.000 Health - Hospital Indemnity	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Kathryn Gurnett	Disposition Date: 12/01/2008
	Date Submitted: 12/01/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: B360 & A142-1	Status of Filing in Domicile: Authorized
Project Number: B360 & A142-1	Date Approved in Domicile: 11/14/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 12/01/2008	
State Status Changed: 12/01/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

RE: Physicians Mutual Insurance Company – NAIC 80578; FEIN 47-0270450

B360C – Pre-Existing Conditions Amendment Rider

A142AR-1 – Application for Health Insurance & Variables

OC142-1 - Outline of Coverage

Actuarial Memorandum – Policy P142AR with Rider B360

Actuarial Memorandum – Payroll Deduction Factor for Policy P142AR

SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

The above captioned forms are enclosed for your review and approval. Rider B360C is new and does not replace any previously approved forms. Application A142AR-1 replaces application A142AR previously approved by your Department on January 3, 2003. To the best of my knowledge, these forms comply with all state laws and regulations.

The P142AR is a limited benefit Hospital, Medical, Surgical Indemnity Policy. The A142AR-1 application enables simplified, less stringent, underwriting requirements for the P142AR policy allowing more applicants to qualify for health coverage. Rider B360C adds a one year waiting period for pre-existing health conditions to all future issues of the P142AR policy and offsets the cost of accepting additional health risks due to the reduced underwriting requirements. No changes to P142AR premiums are required and no in force policies are affected. The rider also modifies the current language of the Time Limit on Certain Defenses provision and the policy definition of Sickness to effectively align with simplified underwriting and the addition of the one year exclusion for pre-existing conditions. The language of those current P142AR policy provisions is inconsistent with the proposed changes. All P142AR policies with Rider B360C will be considered a separate class of business for rating purposes and any future rate adjustments applied to this class (if required) will not apply to in force policies without the rider. The proposed changes should provide more prospects with access to at least some level of health coverage at a relatively affordable premium. A new P142AR payroll deduction rate factor is also being filed to allow a discount for employees paying premium through payroll deduction.

Application A142AR-1 will be used for soliciting the following forms:
• P142AR Hospital, Medical, Surgical Indemnity Policy (approved 1/3/03) with B360C Pre-Existing Conditions Amendment Rider
• C250C Dental Policy/Certificate (approved 7/21/03)
• P176AR Specified Disease Policy and optional B276 & B277 benefit riders (all previously approved 12/21/06)

All of the above new forms and rate calculations are applicable only to new policies issued after state approval and internal implementation. These forms may be used by our Agency and Direct Response distribution channels.

We reserve the right to alter the format of the forms submitted without re-filing due to future technology changes (i.e. paper size, font, font type, line ending or page ending changes). Be assured that any minimum font size requirements will be met. Any changes to wording or content would be filed prior to approval.

Your early review and approval of this filing would be greatly appreciated. If you have any questions, please contact me at the e-mail address, fax, or phone number listed below.

SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

Sincerely,

Kathryn R. Gurnett, MBA, CPCU, CLU, HIA, AAPA, AIRC, FLMI, CCP
Policy Approval and Compliance Coordinator
Government and Industry
Voice: (402) 633-1188
Fax: (402) 633-1096
E-mail: katie.gurnett@physiciansmutual.com

Company and Contact

Filing Contact Information

Kathryn Gurnett, Policy Approval & Compliance Coordinator	katie.gurnett@physiciansmutual.com	
2600 Dodge Street	(402) 633-1188 [Phone]	
Omaha, NE 68131	(402) 633-1096[FAX]	

Filing Company Information

Physicians Mutual Insurance Company	CoCode: 80578	State of Domicile: Nebraska
2600 Dodge Street	Group Code: 367	Company Type:
Omaha, NE 68131	Group Name:	State ID Number:
(402) 633-1188 ext. [Phone]	FEIN Number: 47-0270450	

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Mutual Insurance Company	$40.00	12/01/2008	24214909

SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
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Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/01/2008	12/01/2008

SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

Disposition

Disposition Date: 12/01/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Variables for A142AR-1	Approved-Closed	Yes
Form	PRE-EXISTING CONDITIONS AMENDMENT RIDER	Approved-Closed	Yes
Form	APPLICATION	Approved-Closed	Yes
Form	OUTLINE OF COVERAGE	Approved-Closed	Yes

SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

Form Schedule

Lead Form Number: B360

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	B360C	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	PRE-EXISTING CONDITIONS AMENDMENT RIDER	Initial		46	B360C.pdf
Approved-Closed	A142AR-1	Application/Enrollment Form	APPLICATION	Initial		50	A142AR-1.pdf
Approved-Closed	OC142-1	Outline of Coverage	OUTLINE OF COVERAGE	Initial			OC142-1.pdf

PRE-EXISTING CONDITIONS AMENDMENT RIDER

This Amendment Rider is made a part of and amends the Policy to which it is attached. It is subject to all Policy provisions not in conflict with the provisions of this Rider. It takes effect on the Effective Date of the Policy. The Policy is amended as described below:

1. **The following provision is added to the Policy:**

   PRE-EXISTING CONDITION LIMITATION

   We will not pay for a Covered Person's loss if it begins within 12 months after the Effective Date of such Covered Person's coverage and is due to a "Pre-Existing Condition."

   A "Pre-Existing Condition" is a medical condition for which treatment or advice was received or recommended, or produced symptoms which would cause an ordinarily prudent person to seek medical diagnosis, care, or treatment, within the two year period before the Effective Date of a Covered Person's coverage.

2. **The language of the TIME LIMIT ON CERTAIN DEFENSES provision of the Policy is deleted in its entirety and replaced with the following:**

   TIME LIMIT ON CERTAIN DEFENSES

   For loss that starts within three years from the Effective Date, misstatements made in the Application may be used to void the Policy or deny any claim. For loss that starts after three years from the Effective Date, only fraudulent misstatements may be used to void the Policy or deny any claim.

   This provision shall also apply to any:

   1. Covered Person added after this Policy has been issued. The date the Covered Person is added to this Policy is the Effective Date for such Covered Person;
   2. Rider attached to this Policy. In applying this provision the word "Rider" shall be substituted for the word "Policy" wherever the word "Policy" appears; or
   3. Reinstatement based on an Application. In applying this provision to a Policy reinstated on the basis of an Application, "Reinstatement Date" shall be substituted for the words "Effective Date".

3. **The definition for "Sickness", in the DEFINITIONS section of the Policy, is deleted in its entirety and replaced with the following:**

   SICKNESS: A disease, disorder, illness, or physical condition that causes loss beginning after the Effective Date of the Policy and while the Policy is in force for the Covered Person.

Signed, for Physicians Mutual Insurance Company

R. A. Reed

President

Physicians Mutual Insurance Company
2600 Dodge Street, Omaha, Nebraska 68131
Application for Health Insurance [P142, P176, C250A]

GENERAL INFORMATION

(Include all family members proposed for coverage, if additional space is needed please use form AM5-1296.)

Applicant's Name ____ (Prefix, First, M.I., Last, Suffix) Birthdate ____ (Mo. Day Year) Age ____ ☐ Female ☐ Male

Height ____ Weight ____

Resident Address [Line 1] ____

[Line 2] ____

City, State, Zip ____

Alternate Address [Line 1] ____

[Line 2] ____

City, State, Zip ____

Home Phone # Area Code ( ) ____ Work Phone # Area Code ( ) ____ Cell Phone # (optional) Area Code ( ) ____

Applicant's SSN ____ E-Mail Address: (optional) ____

Occupation: ____ Describe Duties: ____

Is this a Child Only application? ☐ Yes ☐ No If Yes, Policyowner Name ____

Policyowner Address [Line 1] ____ Policyowner Social Security # ____

[Line 2] ____

City, State, Zip ____

Relationship to Applicant ☐ Parent ☐ Legal Guardian Policyowner Date of Birth ____

Spouse's Name *(if applicable)* ____ (Prefix, First, M.I., Last, Suffix) Birthdate ____ (Mo. Day Year) Age ____ ☐ Female ☐ Male

Spouse's SSN ____ Height ____ Weight ____

Occupation: ____ Describe Duties: ____

Dependent's Name *(if applicable)* ____ (First, M.I., Last, Suffix) Birthdate ____ (Mo. Day Year) Age ____ ☐ Female ☐ Male

Dependent's SSN ____ Currently attending college, vocational or technical school? ☐ Yes ☐ No Height ____ Weight ____

Educational institution and phone number *(if applicable)* ____ # of credit hrs. ____

Dependent's Name *(if applicable)* ____ (First, M.I., Last, Suffix) Birthdate ____ (Mo. Day Year) Age ____ ☐ Female ☐ Male

Dependent's SSN ____ Currently attending college, vocational or technical school? ☐ Yes ☐ No Height ____ Weight ____

Educational institution and phone number *(if applicable)* ____ # of credit hrs. ____

Dependent's Name *(if applicable)* ____ (First, M.I., Last, Suffix) Birthdate ____ (Mo. Day Year) Age ____ ☐ Female ☐ Male

Dependent's SSN ____ Currently attending college, vocational or technical school? ☐ Yes ☐ No Height ____ Weight ____

Educational institution and phone number *(if applicable)* ____ # of credit hrs. ____

SECTION [B]

Are all persons proposed for coverage U.S. citizens? . . . . . ☐ Yes ☐ No

If no, have they resided in the United States for more than 2 years and are permanent residents? . . . . . ☐ Yes ☐ No

(If yes, please provide a copy of their green card for [P176] only.)

Are you or anyone applying for this coverage currently eligible for Medicaid or Medicare? . . . . . ☐ Yes ☐ No

COVERAGE SPECIFICATIONS

SECTION [C]

(Can apply for one or more policies.)

Requested Effective Date[*] _____

[Policy Kind **P142**] ☐ Hospital, Medical, Surgical Indemnity Policy

Requested Effective Date[*] _____

[Certificate Kind **C250A***] ☐ Dental Certificate

Choose Your Level of Benefits (check one)

☐ Schedule A ☐ Schedule B ☐ Schedule C ☐ Schedule D ☐ Schedule E ☐ Schedule F

[*This Dental plan is issued to the Delaware Group Insurance Trust.]

Requested Effective Date[*] _____

[Policy Kind **P176**] ☐ Specified Disease Policy

Choose Your Level of Benefits (Check One) ☐ 1 Unit ☐ 2 Units

Optional Riders (Children are not eligible for Rider B276)

☐ B276, First Diagnosis Critical Illness Benefit Rider
(Select Benefit Level)
☐ $5,000 Maximum ☐ $10,000 Maximum ☐ $20,000 Maximum

☐ B277, First Diagnosis Internal Cancer Benefit Rider
(Select Benefit Level)
☐ $2,500 Benefit ☐ $5,000 Benefit ☐ $10,000 Benefit

Will this coverage replace any existing health insurance currently in force? ☐ Yes ☐ No

Company _____ Type of Coverage _____

Termination Date of Coverage _____

**Requested Effective Date must be the same as other medical coverage applied for on this application.*

SECTION [D]

Payment Method Options (check one)

☐ Automatic Bank Withdrawal (monthly mode only) ☐ Credit Card MC\VISA (monthly mode only) ☐ Direct Bill ☐ Payroll Deduction

Payment Mode Options (Check one)

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

/ /		$	$
Date of Application	Requested Effective Date	Premium Collected	Modal Premium

SECTION [E] - HEALTH STATEMENT FOR HOSPITAL/MEDICAL/SURGICAL POLICY [P142]

1. Within the last 5 years, has anyone proposed for coverage had any diagnosis of, received any treatment for, or consulted with a medical practitioner concerning any:

   a) Stroke or disease or disorder of the heart, coronary arteries, or carotid arteries (excluding high blood pressure or high cholesterol)? ☐ Yes ☐ No
   b) Internal Cancer (including melanoma but not other skin cancer), leukemia, carcinoma in-situ, or Hodgkin's Disease? ☐ Yes ☐ No
   c) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), AIDS related conditions, or tested positive for the Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
   d) Type I diabetes, Juvenile diabetes, kidney failure or dialysis? ☐ Yes ☐ No
   e) Chronic lung disorder (not including acute bronchitis or asthma)? ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s): _____

2. Has anyone proposed for coverage been hospitalized or confined to a nursing home for any reason within the last 12 months? ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s): _____

3. Has anyone proposed for coverage consulted with or been advised by a medical practitioner to have any surgeries which have not yet been performed? ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s): _____

4. Do any of the following apply to you, an immediate family member, or any person dependent on you for financial support? (This question applies whether or not such person is listed on the application.):

   a) Currently pregnant (expectant mother)? ☐ Yes ☐ No
   b) Father of any expected child (expectant father)? ☐ Yes ☐ No
   c) Currently in the process of adopting a child? ☐ Yes ☐ No
   d) Received, or recommended to receive, any type of infertility medication or treatment within the last five years? ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s): _____

   Any persons named in (1), (2), (3), or (4) above will not be covered under the policy.

5. Has anyone proposed for coverage used tobacco in any form in the last 12 months? ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s): _____

SECTION [F] - HEALTH STATEMENT FOR SPECIFIED DISEASE POLICY [P176]

1. Has anyone proposed for coverage ever had any symptoms of, had any diagnosis of, received treatment for, or consulted with a medical practitioner concerning any form of cancer (excluding non-melanoma skin cancer), melanoma, leukemia, Hodgkin's Disease, pre-malignant lesions, carcinoma in-situ, Acquired Immune Deficiency Syndrome (AIDS), positive HIV or AIDS Related Complex (ARC)? ☐ Yes ☐ No If "Yes", identify name(s) of person(s): _____

2. Within the last 3 years, has anyone proposed for coverage had any symptoms of, had any diagnosis of, received treatment for, or consulted with a medical practitioner concerning non-melanoma skin cancer? ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s): _____

   Any persons named in (1) or (2) above will not be covered under the policy and benefit riders.

3. Within the last 12 months, has anyone proposed for coverage had, or been advised by a medical professional to have, any examinations, surgery, or other medical tests to confirm, exclude, or screen for the presence of cancer (including melanoma and other skin cancers), leukemia, Hodgkin's Disease, pre-malignant lesions, carcinoma in-situ, AIDS, HIV, or any immune deficiency disorder, which have not yet been completed, or for which test results were abnormal or are still pending? ☐ Yes ☐ No

   If "Yes", identify name(s) of person(s): _____

   Any persons named in (3) above will not be covered under the policy and benefit riders, but may reapply once diagnostic procedures and results are complete.

SECTION [F] - HEALTH STATEMENT FOR SPECIFIED DISEASE POLICY [P176] - Continued

First Diagnosis Critical Illness Benefit Rider (Ask only if adding Rider B276. Children are not eligible.)

4. Has anyone proposed for coverage ever had any symptoms of, had any diagnosis of, received treatment for, or consulted with a medical practitioner concerning congestive heart failure, valvular heart disease, angina, coronary heart disease, heart rhythm disorder, aneurysm, stroke, cerebral vascular accident or disease, transient ischemic attack (TIA), carotid artery disease, or diabetes? ☐ Yes ☐ No If "Yes", identify name(s) of person(s): _____

Any persons named in (4) above will not be covered under the optional First Diagnosis Critical Illness Benefit Rider.

APPLICANT'S STATEMENT

I represent that my answers and statements in this application are true and complete to the best of my knowledge and belief and I understand they are material to issuance of this policy. I agree that the Company is not bound by any statement made to the agent unless written on this Application. I understand that: (1) no insurance will be effective on the Requested Effective Date unless this Application is approved, the Policy issued, and the first full premium has been paid, and no change has occurred in the health of any person to be insured at the time of the Company's approval of the application; (2) any information misrepresented or not disclosed by me in this Application may result in the denial of claims, the addition of an exclusionary rider, additional premium, or voiding of the Policy.

This statement applies only to applicants applying for Hospital/Medical/Surgical Policy [P142]: I understand that no benefits are payable for any loss beginning within one year after the effective date of a covered person's coverage if such loss is due to a pre-existing condition.

This statement applies only to applicants applying for Specified Disease Policy [P176]: I understand that no benefits are payable for cancer or any other covered condition that occurs or is diagnosed: (1) within the first 30 days after the effective date of a covered person's coverage; or (2) within two years after the effective date of a covered person's coverage if such loss is due to a pre-existing condition. I further understand that no cancer screening benefits are payable during the first 180 days after the effective date of a covered person's coverage.

This statement applies only to applicants applying for Dental Certificate [C250]: I am applying for Certificate C250 and the plan selected issued to the Delaware Group Insurance Trust. I understand no coverage is in force until the Company issues a certificate showing a Certificate Effective Date and the first full premium has been paid.

I represent that the Applicant's signature below is the original, personal signature of the Applicant. **The Applicant must sign personally. Signatures under power of attorney will not be accepted.** *This representation does not apply to a Child Only Application (when a parent or legal guardian signs the Application on behalf of a child Applicant).*

Fraud Warning: Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

_____ Signature of Agent

_____ Signature of Applicant
(For Child Only Application: Signature of Parent/Legal Guardian)

Date Application Completed _____
Mo. Day Year

[P142] AND [P176] LIMITED BENEFIT POLICY DISCLOSURE STATEMENT

I understand that this Policy is a Limited Benefit Health Policy and does not provide comprehensive major medical benefits.

Signature of Applicant (in ink) **X** _____ Date _____

PHYSICIANS MUTUAL INSURANCE COMPANY
LIMITED BENEFIT HEALTH COVERAGE
HOSPITAL, MEDICAL, AND SURGICAL INDEMNITY POLICY
BENEFITS PROVIDED ARE SUPPLEMENTAL AND
ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES
OUTLINE OF COVERAGE – P142

READ YOUR POLICY CAREFULLY: This Outline of Coverage provides a very brief description of some important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Your insurance Company. It is therefore, important that You READ YOUR POLICY CAREFULLY!

LIMITED BENEFIT HEALTH COVERAGE is designed to provide, to persons Insured, limited or supplemental coverage.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.

BENEFITS

HOSPITAL CONFINEMENT BENEFIT: We will pay the Daily Room Benefit of [$500.00] for each of the first fifteen (15) days a Covered Person is confined, as an inpatient, in a Hospital due to Sickness or Injury. After the first fifteen (15) days, We will pay one-half the Daily Room Benefit for each additional day a Covered Person is confined, as an inpatient, in a Hospital. Hospital confinements less than sixty (60) days apart and due to the same conditions are deemed one (1) Hospital confinement if the Policy remains in force.

We will pay two (2) times the Daily Room Benefit for each of the first fifteen (15) days a Covered Person is confined in the Intensive Care Unit (ICU) of a Hospital. After the first fifteen (15) days, We will pay the Daily Room Benefit for each additional day a Covered Person is confined in the Intensive Care Unit (ICU) of a Hospital.

SURGERY BENEFIT: We will pay the Surgery Benefit for a surgical procedure performed on a Covered Person due to Sickness or Injury with a maximum of [$3,000.00]. For surgical procedures other than those listed in the Surgery Schedule, We will pay a relative value comparable to the listed procedures.

You may only receive one (1) Surgery Benefit in any one (1) day. If more than one (1) surgery is performed on the same day, We will pay for only one (1), the one resulting in the highest benefit. If more than one (1) procedure is performed through the same incision, We will pay for only one (1), the one resulting in the highest benefit.

AMBULANCE BENEFIT: We will pay the Ambulance Benefit of [$250.00] for ambulance service to a Hospital in the immediate area for Emergency Medical Care. The Ambulance Benefit is payable up to five (5) times for each Covered Person in any one (1) Calendar Year. This benefit is not payable for air ambulance service.

AIR AMBULANCE BENEFIT: We will pay the Air Ambulance Benefit of [$1,000.00] for air ambulance services. Air ambulance services must be: (a) needed for Emergency Medical Care or needed because of

Sickness or Injury that requires medical treatment not available in the immediate area; and (b) in an aircraft used primarily for transporting sick or injured persons. The Air Ambulance Benefit is payable up to five (5) times for each Covered Person in any one (1) Calendar Year.

GENERAL ANESTHESIA BENEFIT: We will pay the General Anesthesia Benefit of [$500.00] when a Covered Person receives general anesthesia related to a surgery for which benefits are paid under this Policy.

MISCELLANEOUS OUTPATIENT SURGERY BENEFIT: We will pay the Miscellaneous Outpatient Surgery Benefit of [$75.00] when a covered outpatient surgery is performed on a Covered Person. This benefit will be paid in addition to any benefit paid under the Surgery Schedule, and is payable up to five (5) times for each Covered Person in any one (1) Calendar Year. All outpatient surgeries performed on the same day will be considered one (1) outpatient surgery.

MISCELLANEOUS OUTPATIENT NON-SURGICAL BENEFIT: Pays the Miscellaneous Outpatient Non-Surgical Benefit of [$20.00] when a Covered Person receives medical treatment (non-surgical) for up to five (5) times each Calendar Year.

HOME HEALTH CARE BENEFIT: We will pay the Home Health Care Benefit of [$20.00] for each day a Covered Person receives Home Health Care for up to twenty-five (25) days for each Covered Person who receives Home Health Care following any one (1) covered Hospital confinement. Hospital confinements less than sixty (60) days apart and due to the same conditions are deemed one (1) Hospital confinement if the Policy remains in force. We will pay up to fifty (50) days of Home Health Care for each Covered Person in any one (1) Calendar Year. Such Home Health Care must: (a) be for the care and treatment of a Sickness or Injury where Hospital confinement would have otherwise been required; (b) be provided under a Home Health Care Plan; and (c) begin within fourteen (14) days of a covered Hospital confinement of at least three (3) consecutive days.

DIAGNOSTIC NUCLEAR BENEFIT: We will pay the Diagnostic Nuclear Benefit of [$150.00] when a Covered Person receives a CAT Scan or Magnetic Resonance Imaging (MRI) test due to Sickness or Injury.

PREVENTIVE CARE BENEFIT: After a one hundred eighty (180) day waiting period from the Effective Date of the Policy, We will pay the Preventive Care Benefit when a Covered Person receives preventive care as outlined below:

(1) Pap Smear - We will pay the Pap Smear benefit of [$75.00] for one (1) routine Pap Smear for each Covered Person in each Calendar Year.

(2) Mammogram - We will pay the Mammogram benefit of [$100.00] for one (1) baseline Mammogram payable for women ages thirty-five (35) through thirty-nine (39) years of age; and one (1) Mammogram each Calendar Year for women forty (40) years of age and older.

(3) Prostate Cancer Screening - We will pay the Prostate Cancer Screening benefit of [$75.00] for one (1) routine Prostate Cancer Screening for each Covered Person in each Calendar Year, including digital rectal examination and prostate-specific antigen testing.

(4) Childhood Immunization - We will pay the Childhood Immunization benefit of [$35.00] for one (1) Childhood Immunization per Calendar Year for each covered child for the following Childhood Immunizations: Diphtheria, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella, Hemophilus Influenzae Type B and any other Immunization subsequently required by law.

PRE-EXISTING CONDITION LIMITATION

We will not pay for a Covered Person's loss if it begins within 12 months after the Effective Date of such Covered Person's coverage and is due to a "Pre-Existing Condition."

A "Pre-Existing Condition" is a medical condition for which treatment or advice was received or recommended, or produced symptoms which would cause an ordinarily prudent person to seek medical diagnosis, care, or treatment, within the two year period before the Effective Date of a Covered Person's coverage.

EXCLUSIONS AND LIMITATIONS

No benefits under the Policy are payable for any of the following:
(1) Any loss that occurs while the Policy is not in force, except as provided in the Extension of Benefits provision.
(2) Care and treatment that is a result of participating in a riot or that results from an attempt to commit, or committing, an assault or crime by the Covered Person.
(3) Care and treatment provided mainly for cosmetic reasons, including but not limited to complications of any cosmetic surgery or complications, revisions or Injury to cosmetic breast implants. This exclusion will not apply if the care and treatment:

(a) is for repair of damage from an accident (other than Injury to cosmetic breast implants) that occurred while the person was covered under the Policy;
(b) is due solely to surgical removal of all or part of the breast tissue because of an Injury or Sickness of the breast as shown in the Benefit Provisions; or
(c) is to correct a congenital anomaly in a child.

(4) Care and treatment as a result of an intentionally self-inflicted Injury.
(5) Any loss that is due to an act of declared or undeclared war.
(6) Care and treatment for which there would not have been a charge if no insurance had been in force.
(7) Care and treatment which are received outside of the fifty (50) United States and the District of Columbia.
(8) Any Injury resulting from piloting a private aircraft, sky diving, hang gliding, ultralight flying, scuba diving, rodeo, any type of motorized vehicle racing, rock or mountain climbing, professional athletics.
(9) Non-surgical spinal treatment.
(10) Confinement for Injury sustained while under the influence of alcohol or any controlled substance, drug, hallucinogen, or narcotic not taken on the advice of, and in accordance with the direction of, a Physician.
(11) Treatment due to drug or alcohol abuse.
(12) Mental or nervous disorder, unless resulting from organic disease including Alzheimer's.
(13) Normal child birth, normal pregnancy, and voluntary induced abortion, not to include complications of pregnancy.
(14) Care, treatment, or surgery for mouth conditions that:

(a) are due to periodontal or periapical disease;
(b) involve any of the teeth or surrounding tissue or structure; or
(c) involve the alveolar process or gingival tissue;

except as shown in Benefit Provisions.
(15) Vision evaluation, lenses for the eye and exams for their fitting.
(16) Care, treatment or surgery for elective vision correction.
(17) Hearing aids and hearing evaluations.
Benefits for Hospital confinement in a U.S. Government Hospital are limited to thirty-one (31) days each Calendar Year for each Covered Person unless the Covered Person has a legal liability to pay for such confinement.

RENEWAL AGREEMENT

This Policy is renewable or will continue in force, at Your option unless:
(1) Your renewal premium is not received before the Grace Period ends;
(2) We refuse to renew all Policies of this form in Your state of residence; or
(3) After the Effective Date of the Policy, You perform an act or practice that constitutes fraud or make an intentional misrepresentation of material fact under the terms of this Policy; or
(4) You become sixty-five (65) years of age or eligible for Medicare. In either event, this Policy will automatically terminate on the next premium due date. If We accept Your premium and know You are sixty-five (65) or eligible for Medicare, coverage continues to the end of the premium period. If We accept Your premium and do not know You are eligible for Medicare, We will refund the premium paid less claims paid back to the date of termination.
No refusal of renewal will affect an existing claim.

PREMIUM CHANGES

Premiums will increase each Calendar Year based on the attained age of You or a covered spouse. We may also change Your renewal premium at any time for this Policy or attached Riders, but only if the same change is made by Us on all Policies of this form and class in the state where You live. However, no Premium Change can be made by Us earlier than twelve (12) months after the Effective Date of the Policy unless You move to a new ZIP Code, You request a change in Your Policy Benefits or Riders or there is a change in dependent status.

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, PLEASE CONTACT US TOLL-FREE AT [1-800-228-9100]. PHYSICIANS MUTUAL INSURANCE COMPANY, [PO BOX 2018, OMAHA, NE 68103-2018.]

SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PHYS-125919161*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*40979*
Company Tracking Number:			
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*B360 & A142-1*		
Project Name/Number:	*B360 & A142-1/B360 & A142-1*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 12/01/2008

Comments:

Attachments:

AR Readability Cert.pdf

Ar reg 19 cert.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 12/01/2008

Comments:

Please see filing description under General Information tab and the Form Schedule.

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 12/01/2008

Comments:

Please see form schedule.

Satisfied -Name: Variables for A142AR-1 **Review Status:** Approved-Closed 12/01/2008

Comments:

Attachment:

A142 Variables C250.pdf

PHYSICIANS MUTUAL INSURANCE COMPANY

OMAHA, NEBRASKA

Certification of Flesch

The form has the following Flesch Readability Score:

Form	Flesch Score
B360C	46.4
A142AR-1	49.9

The entire form was analyzed. The following was excluded in the text: name and address of the insurer; name, number and title of the form; captions and sub-captions; medical terminology; defined terms.

Shawn Pollock
Vice President
Government and Industry

12-01-08
Date

CERTIFICATION

RE: B360C, A142AR-1, OC142-1

This is to certify that the above captioned filing complies with Arkansas Regulation 19 and all other applicable requirements of the Arkansas Insurance Department.

Date: December 1, 2008

Shawn Pollock
Vice President
Government and Industry

A142-1 Application Form Variables – C250

All section lettering is subject to change to line up sections in alpha order.

Section A
May remove height and weight fields, occupation, and occupational duties if application is used as C250 application only.
[Line 1] may be called street address.
[Line 2] may be called apartment.

Section B
We would remove the entire section if application was used for C250 application only.

Section C
May add/change/delete the layout, format, and copy in the Coverage Specifications section pertaining to the riders or additional coverages offered. May also change the Dental Trust Information if a change occurs in our Trust Agreement. May remove language about common effective dates.

Section D
May add/change/delete or substitute applicable copy for Payment Method Options and Payment Mode Options. Options will include monthly, quarterly, semiannual, annual, credit card, electronic funds transfer, payroll deduction and direct billing. These may be used singularly or in combination. This would include adding/changing/deleting copy for account numbers, expiration dates, "Make check or money order payable to PHYISICANS MUTUAL INSURANCE COMPANY', account/financial institution, combining two different payment options, credit card number/expiration date, credit card holders signature line, and "Direct Billing Available" as appropriate.

Section E
Will only add or remove the entire section depending on if the P142 is offered on the application. The questions will not change. It is an all or nothing section.

Section F
Will only add or remove the entire section depending on if the P176 is offered on the application. The questions will not change. It is an all or nothing section.

Applicant Statement
Variable Box 1 – Will only add or remove the entire section depending on if the P176 and/or P142 are offered on the application. No copy will change; it is an all or nothing box.

Variable Box 2 – Will only add or remove the entire section depending on if the P142 is offered on the application. No copy will change; it is an all or nothing box.

Variable Box 3 – Will only add or remove the entire section depending on if the P176 is offered on the application. No copy will change; it is an all or nothing box.

Variable Box 4 – Will only add or remove the entire section depending on if the C250 is offered on the application. No copy will change; it is an all or nothing box.

Limited Benefit Policy Disclosure Statement
Will not be included if application is ever set up to be used as C250 only.